Medicaid Information Bulletin

July 2006

Web address: http://health.utah.gov/medicaid

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BULLETINS BY TYPE OF SERVICE

On-Line (Internet) Address for Medicaid:

http://health.utah.gov/medicaid

Please make sure that any Medicaid bookmarks that you have are the new Medicaid Internet address shown above. The old web site has been discontinued.

World Wide Web: http://health.utah.gov/medicaid (Formerly http://www.health.state.ut.us/medicaid)

Medicaid Information

- **Salt Lake City area, call 538-6155.**
- **In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.**
- **From other states, call 1-801-538-6155.**

Requesting a Medicaid publication?

Send a Publication Request Form.

- **by FAX: 1-801-536-0476**
- **by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106**

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06 - 63 Electronic Funds Transfer (EFT)

Medicaid is making Electronic Funds Transfer, also known as Direct Deposit, mandatory for all Medicaid enrolled providers effective, July 1, 2006. This means that you will no longer be receiving a paper check after July 3, 2006.

If you still have not enrolled, you have a limited time period to meet the deadline of July 1, 2006. To enroll, please submit a completed EFT form, along with a copy of a voided check or a letter from your bank stating your bank routing number and bank account number. The mailing address for Provider Enrollment is P O Box 143106, Salt Lake City, UT 84114-3106.

The EFT form is available on the Medicaid web site, at http://health.utah.gov/medicaid/ under "Enroll as a Utah Medicaid Provider". If you would like an EFT form sent to you or if you have any questions, contact Provider Enrollment at (801) 538-6155 or toll free at 1 (800) 662-9651, press option 3 then 4.

If you will not be able to begin receiving your payments through the EFT process by July 1, 2006, then you will need to submit a written request for a waiver by June 30, 2006 to:

Brenda R. Bryant, Assistant Director
Division of Health Care Financing
P O Box 143106
Salt Lake City, Utah 84114-3106

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*** IMPORTANT INFORMATION ***

06 - 64 National Provider Identifier

Time is marching on and only about two percent of Medicaid enrolled providers have submitted an NPI to Provider Enrollment for cross-walking to a current Medicaid provider number. Medicaid strongly recommends that providers apply for an NPI, submit this identifier to Medicaid, and begin billing both numbers electronically starting October 1, 2006 to May 22, 2007. This will facilitate the testing and transition processes and will also decrease the possibility of any interruption in claims payment.

If you currently have an NPI, please fax it to (801)536-0471 or mail the information along with your Provider Name and Medicaid Provider Number to Medicaid Provider Enrollment, P O Box 143106, Salt Lake City, UT 84114-3106.

To apply for an NPI online, visit: https://nppes.cms.hhs.gov or call 1-800-465-3203 to request a paper application.
Visit the Medicaid Website at http://www.health.utah.gov/medicaid for additional NPI useful links and training resources.

Medicaid staff are currently working with the UHIN National Provider ID Subcommittee and NMEH NPI Sub-Workgroup to assist in the implementation of NPI.

Medicaid will keep you informed of our progress with implementing the NPI. ☐

06 - 65 NPI: Electronic File Interchange (EFI) or aka Bulk Enumeration is Now Available

Beginning May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) announced the capability for health industry organizations to submit health care providers' applications for National Provider Identifiers (NPIs) to the National Plan and Provider Enumeration System (NPPES) via Electronic File Interchange (EFI). With EFI, a CMS-approved health industry organization can submit a health care provider's NPI application data, along with the application data of many other health care providers, in a single electronic file in a CMS-specified format. EFI is an alternative to health care providers having to apply for their NPIs via the web-based or paper application process. After the NPPES processes a file, it makes available to the organization, a downloadable file containing the NPIs of the enumerated health care providers. Interested health industry organizations should visit www.cms.hhs.gov/nationalprovidentstand/ for the latest EFI materials available from the CMS NPI page, and from the NPPES page at https://nppes.cms.hhs.gov/ before downloading and completing a Certification Statement and registering as EFI Organizations. A completed Certification Statement must be approved by CMS before a health industry organization can participate in EFI. ☐

06 - 66 Revised CMS 1500 Health Insurance Claim Form

A new CMS 1500 Claim Form is being released for public use. Medicaid will begin accepting the new paper form beginning October 1, 2006. During a transitional period, October 1, 2006 through January 31, 2007, multiple versions will continue to be accepted. Effective February 1, 2007, Medicaid will accept only the revised CMS 1500 (version 08/05). The release of the new claim form will accommodate the reporting of the National Provider Identifier (NPI).

Providers should contact their vendors to prepare for the changes.

Medicaid encourages electronic submissions of claims. Providers interested should contact the Utah Health Information Network (UHIN) at (801) 466-7705 or online at http://health.utah.gov/hipaa and access Enrollment.

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06 - 67 Billing Form for Ambulatory Surgical Centers

Ambulatory Surgical Centers should utilize the 837P electronic format or CMS 1500. Medicaid had announced in the July 2005 MIB (Article 05-80) they would be utilizing the 837I or UB92; however, this was in error. Please continue using the 837P or CMS 1500 until further notice.

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06 - 68 Submission of Replacement/Void Claims

Providers should submit their own corrections by submitting either a replacement or void claim. The data elements needed to identify a replacement or void claim are:

Claim Frequency Code - Acceptable values: 7 for replacement, 8 for void
- Electronic: X12 element 2300 CLM05-3
- Paper: UB92 - Form Locator 4, position 3
  - CMS1500 - Box 22 (Code)
  - Dental - Process not available on paper.

Original Reference Number - Transaction Control Number (TCN) of original claim.
- Electronic: X12 element 2300 REF02
- Paper: UB92 - Form Locator 37 A-C (same line as Medicaid in 50A-C)
  - CMS1500 - Box 22 (Original Ref. No.)
  - Dental - Process not available on paper.

The following are frequent issues identified with replacement/void claims:

1. The provider number on the original claim must match the provider number being submitted on the replacement claim.
2. If the TCN of the original claim cannot be identified in the Medicaid system, the replacement/void claim will be rejected.
3. Replacement claim(s) void the original claim. The replacement claim is then processed in the Medicaid system as an original.
4. If there are additional services, or services not paid on the original claim, it is not necessary to submit a replacement claim. You may submit a new claim for only the services not paid on the original claim. However, if additional units are being added to an already paid line or you are changing procedure codes, a replacement claim must be submitted.
5. If the original claim was denied, it is not necessary to submit a replacement claim. Make the necessary correction(s) and resubmit the claim as an original claim.
6. If wanting to replace an original claim that was split by Medicaid for processing, it is necessary to submit a void claim for each of the split claims. A new original claim could then be submitted for processing.
7. If a claim was paid under the wrong provider number, submit a void claim with the provider number of the original claim and a new original claim with the correct provider number.

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06 - 69 HCPCS Codes Discontinued

The quarterly HCPCS website has indicated that the following S-Codes will be discontinued effective July 1, 2006.

S0116 Bevacizumab, 100 MG
S0198 Injection, Pegaptanib Sodium, 0.3 MG
S8075 Computer Analysis of full-field digital mammogram
S9022 Digital subtraction angiography

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06 - 70 Coding Changes

Codes Covered

S2075 Laprascopic repair incisional or ventral hernia
96416 . . . initiation of prolonged chemotherapy infusion (> 8 hours), requiring use of portable or implantable pump
Note: The portable pump will not be separately reimbursed.

Codes for Manual Review

61322 Craniectomy or craniotomy, decompression, with or without duraplasty . . . without lobectomy
PRIOR APPROVAL: Not Required . . . . . CRITERIA: Attach documentation to claim.
61323 . . . with lobectomy
PRIOR APPROVAL: Not Required . . . . . CRITERIA: Attach documentation to claim.
71250 Computed Tomography, thorax; without contrast material
PRIOR APPROVAL: Not Required ICD9: 87.41 . . . . . Refer to Criteria #40A[2]
71260 Computed Tomography, thorax; with contrast material
PRIOR APPROVAL: Not Required ICD9: 87.41 . . . . . Refer to Criteria #40A[2]
71270 Computed Tomography, thorax; without contrast material followed by contrast material and further sequences
PRIOR APPROVAL: Not Required ICD9: 87.41 . . . . . Refer to Criteria #40A[2]
83901 Amplification of patient nucleic acid, each additional nucleic acid sequence
PRIOR APPROVAL: Not Required . . . . . CRITERIA: Attach documentation to claim.
(Covered for medical necessity, but not covered for general genetic screening)
83914 Mutation identification by enzymatic ligation or primer extension (i.e. OLA/SBCE/ASPE)
PRIOR APPROVAL: Not Required . . . . . CRITERIA: Attach documentation to claim.
(Covered for medical necessity, but not covered for general genetic screening)

Codes Covered with Prior Authorization

76093 MRI breast, with or without contrast material, unilateral
Prior authorization: Telephone . . . . . Criteria 40B

76094 MRI breast, with or without contrast material, bilateral
Prior authorization: Telephone . . . . . Criteria 40B

Non-Covered

95120 Professional services for allergen immunotherapy . . . single injection
95125 . . . two or more injections

Edit Changes

Q0081 Home health infusion is mutually exclusive to T1001–Nursing assessment and T1002–RN Home visit

The code combination of 87077 and 87088 is mutually exclusive.

Note: The CMS site for Correct Coding Initiative (CCI) edits: http://www.cms.hhs.gov/NationalCorrectCodInitEd/

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06 - 71 Criterion 46 - Craniectomy or Craniotomy Decompression

Indications

A. The patient has received conservative therapy with continued monitoring for intracranial pressure and P(ti)02 and there is severe brain swelling on CT.
B. In patients with ischemic stroke the surgery is preformed within 24 hours of the onset of increase intracranial pressure and before the occurrence of clinical signs of herniation.
C. In patients with hematomas
   1. The surgery is performed in the absence of other life threatening multiple trauma.
   2. The Glasgow score (GCS) is $\geq$4 and $\leq$8. Research indicates patients with a Glasgow between 6 and 8 are the best candidates for surgical decompression.
   3. The surgery is performed within 48 hours before irreversible brainstem or generalized brain damage has occurred.

Non-Covered

A. Patients with an initial Glasgow score of three who do not improve to a GCS of four and/or have fixed and dilated pupils are not candidates for decompression surgery. ☐

06 - 72 Anesthesia and Pain Management Billing Clarification

When modifier 59 is placed on the claim, the single block or epidural injection for postoperative pain management must be administered separately from the primary anesthesia (before or after the surgery) for full payment of the code. Epidural analgesia may be provided by single injection or continuous infusion. Sometimes placement of an epidural catheter prior to surgery is preferred because the patient can report any accompanying paresthesias and the catheter can be tested prior to surgery. The catheter is left in place for three days or less because the patient usually has recovered sufficiently to allow removal. The epidural catheter placed during the primary anesthesia procedure becomes part of the global anesthesia procedure. Since there are occasions, especially in pediatrics, when it is best to complete the epidural procedure during the primary anesthesia service, Medicaid will pay for the single block injection or epidural catheter placement at one-half the fee schedule rate when the procedure is completed within the primary anesthesia service during surgery for postoperative pain management. For reimbursement of post operative pain management, the postoperative injection or epidural service must be submitted with modifier 59 and the time of placement of the epidural catheter or block injection must be clearly documented in the medical record. Failure to document the services to indicate the procedure was complete prior to surgery, after surgery in the postoperative period, **or** during the primary anesthesia procedure will result in a denial of reimbursement for service. Anesthesia service such as code 00630 delivered for chronic pain management is a non-covered service. Some providers have billed the primary anesthesia service 00630 and a series of block, epidural, and/or trigger point injections for chronic pain management. Chronic pain management is only covered with prior authorization, see criterion 45. Trigger point injections and epidural/block injections for pain management are subject to the limitations described in criterion 34 A&B.

As described in the provider manual, the codes for anesthesia of special circumstance (i.e. 99100, 99116, 99135, 99140) remain non-covered services in Medicaid.

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06 - 73 Criterion 43 - Adult Sleep Studies

For approval of a sleep study, the polysomnography must be completed at an accredited American Academy of Sleep Medicine (AASM) sleep disorder center.

The reference to AHI (B.2.c) was removed. The following information was added related to AHI and CPAP:

C. CPAP is covered under the following conditions:

   1. Polysomnography requires at least six hours of attended sleep through sleep stages with the physiological and pathophysiological parameters reviewed and interpreted by the physician. Documentation to support obstructive sleep apnea during six hours of recorded sleep requires at least 30 episodes of apnea each lasting a minimum of 10

seconds. The diagnosis of sleep apnea requires the calculation of the Apnea-Hyponea Index (AHI). The AHI is the average number of apnea and hypopnea episodes per hour and must be based on a minimum of two hours of sleep recorded by polysomnograpy using actual hours of sleep. The need for CPAP must be documented by **a or b**:

a. An AHI ≥ 15 is documented during a minimum of 2 hours of diagnostic polysomnography.
b. There are AHI ≥ 5 and ≤ to 14 events per hour with documented symptoms of daytime sleepiness, documented hypertension, ischemic heart disease, or history of stroke.

2. For patients with severe and unambiguous obstructive sleep apnea, initial diagnostic polysomnography must meet AHI requirements as outlined above. CPAP titration during polysomnography on the same night may be an alternative to a full night of diagnostic polysomnography as long as the CPAP titration is carried out for at least 3 hours. This titration must provide documented evidence that the CPAP eliminates or nearly eliminates respiratory events during REM and NREM sleep. ☐

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06 - 74 Criterion 40B – MRI Imaging of Knee

Clarification: MRI of Knee coverage policy now requires at least eight weeks of conservative treatment of the knee.

d. Persistent knee pain/swelling and/or instability without an associated injury which is unresponsive to at least **eight** weeks of conservative treatment and after multiple view x-rays the diagnosis remains unclear.

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06 - 75 Criterion 40B - MRI Imaging of Breast

Mammography and ultrasound are still considered the primary tests for breast screening and evaluation. MRI cannot distinguish between cancerous and noncancerous abnormalities or imaging calcifications. A biopsy is still required. MRI will be a covered service as follows:

Indications

A. To detect local tumor recurrence in individuals with breast cancer who have radiographically dense breasts or old scar tissue from previous breast surgery that compromises the ability of combined mammography and ultrasonography.
B. In detecting occult breast cancer in patients with axillary nodal metastasises when there is concern for spread of cancer to the chest wall.
C. To detect local tumor recurrence in patients with breast cancer who have undergone mastectomy or breast reconstruction with implant.

Non-Covered

A. To confirm implant rupture in symptomatic individuals when ultrasonography shows rupture
B. Screen for breast cancer in patients with average risk of breast cancer
C. To diagnose and evaluate a breast lesion prior to biopsy
D. To differentiate benign from malignant breast disease, especially clustered micro-calcifications
E. To differentiate cysts from solid lesions
F. To predict early response of breast cancer to chemotherapy or in guiding choice of chemotherapy
G. To identify multicentric disease in persons with localized breast cancer prior to surgery
H. Mapping the size and extent of primary tumors in persons with localized breast cancer
I. Assessment of patients only because they have prior history of breast cancer
J. To further characterize indeterminate breast lesions identified by clinical examination, mammography, or ultrasound.

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06 - 76 Billing Vaccine For Children (VFC) Services

As a reminder to all Medicaid providers administering vaccines through the Vaccine for Children (VFC) program, antigens provided by the VFC program are not Medicaid reimbursable. Claims for the antigen should be submitted as a $0.00 charge. Claims for the administration of the vaccine are reimbursed at the current rate.

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06 - 77 Private Duty Nursing

The time studies that have been required for private duty nursing (PDN) authorization, are not providing sufficient medical information to justify the hours of PDN that many agencies are requesting. A new tool has been developed to provide the information needed to support medical necessity and provide required care to Medicaid patients.

The following information must be completed by the nurse caring for the patient to indicate the number of skilled nursing services provided. Indicate by number or hashmark the number of services provided. Those with questions should contact the prior authorization nurse for further details.

SKILLED NURSING NEEDS FOR TRACHEOSTOMIZED, VENTILATOR, AND/OR TECHNOLOGY DEPENDENT PATIENTS

Indicate how many times per shift the following are done

Comprehensive Nursing Assessments (How many)_____
Breath Sounds-Auscultation (How many)_____
Before Suction (How many)_____
After Suction (How many) _____
Vital Signs taken (Number of times) _____
Need for Aerosol Treatment (How many)_____

Indicate if any of these occur during shift

Signs and Symptoms/Management

Respiratory Distress (Number of times)_____ Intervention_____
Hypoxia (Number of times)_____ Intervention_____
Tachycardia (Number of times)_____ Intervention_____
Bradycardia (Number of times)_____ Intervention_____
Side effects of medication (Specify) _____
Fluid retention (yes or no)_____ Intervention_____
Seizures (Number of times)_____ Intervention_____
Hyper or Hypotension (Number of times)_____ Intervention_____
Reflux (Number of times)_____

Procedures– indicate how often the following are done during the shift

Suctioning (Number of times) _____ Wound care other than trach _____
*Describe character of secretions*_____
Chest Percussion (Number of times)_____ Dressing changes (not IV related)_____
IV Infusions_____ IV Line Care_____ IV Lab Draws_____
PRN Medications_____ Lab Draws by Venipuncture_____ TPN_____
Passive Range of Motion_____ Active Range of Motion_____
Checking Residuals_____

Note: Medications by mouth or G or J tube and tube feedings are not considered skilled after 60 days

Indicate if any of the following are completed during shift

Trach Care:
Clean trach site
Change trach ties
Change trach tubes
Cleaning of inner cannula
Place on trach collar

Vent Care:
Tubing changes
Vent setting changes

Bagging:
Via Trach
Via Mouth

List other skilled treatments or procedures, be specific_____
_____

RN Signature_____ Date _____

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06 - 78 Advanced Practice Nurse Services

Procedures approved by Medicaid for coverage when delivered by a family nurse practitioner, a pediatric nurse practitioner, a certified nurse midwife, or a certified nurse anesthetist are open for their provider type. Procedures completed outside of the procedures approved by Medicaid are not reimbursable.

When a non-covered procedure (i.e. lumbar puncture) is provided by a nurse practitioner then billed through the collaborating physician, the bill is not considered appropriate. When program integrity identifies non-covered procedures billed through the physician, a refund will be required. Nurse practitioners who have been approved by the Department to perform a specific procedure, based on their training and certifications, are the only individuals who will receive reimbursement for these services.

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06 - 79 IHC Access Changes Name to Select Access

Effective July 1, 2006, IHC Access will change its name to Select Access. The July Medicaid Identification Card for enrolled clients will list **SELECT ACCESS** as the health plan. This is only a name change. **Providers must still submit claims to Medicaid for reimbursement**, **not to Select Access.** Providers must still follow the Medicaid fee-for-service guidelines for billing, prior authorization, etc. When a service for a Select Access member requires prior authorization, a provider must contact Medicaid, not Select Access.

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06 - 80 Program Integrity Unit: Attention All Providers

*** Program Integrity Will Not Maintain Separate Mailing Addresses ***

It is the responsibility of the Program Integrity Unit to provide a post-payment professional evaluation of services provided to Medicaid applicants and recipients to ensure compliance with policy; to reduce and recover inappropriate payments; to safeguard against unnecessary or inappropriate use of Medicaid services; to safeguard against excess payments; to assure that such services are in compliance with current Medicaid (Title XIX) policy and regulations; to assure that such services are sufficient in amount, duration, and scope to reasonably achieve their purpose; and to assess the quality of such services.

The authority for utilization control of care and services for each Medicaid applicant/recipient is found in Title 42 of the Code of Federal Regulations, Part 456, Subpart A and B, Title 42 of Code of Federal Regulations, Part 455, Section 455.14 and 455.15, Preliminary Investigation and System Performance Review Requirements, Factor 22.

As a result of the responsibilities listed above, it is necessary to request records for review. A letter of request is prepared and sent to the mailing address listed on the provider file. This is the address given when you enrolled as a Medicaid provider. If no mailing address was listed, the request will be sent to your service address. If no response is received, a second letter will be sent and you will be notified that Medicaid will recover the amount paid because you failed to respond. At this time you will receive your hearing rights.

It is your responsibility as a provider to update the file if you have a change in address or other conditions that would prevent a correspondence from reaching you. It would be in your best interest to notify provider enrollment if corrections are needed.

Program Integrity can no longer create separate files with alternate addresses to be used when requesting information or sending notifications to your office. You may want to verify with provider enrollment that the mailing address listed is the correct address for correspondence.

Reminder to Providers
Correct Mailing Address for Program Integrity

For the correct handling and delivery of reimbursement checks, records, and other information requested by Program Integrity, it is your responsibility as a provider to use the correct mailing address. Program Integrity will no longer attempt to locate checks or documents mailed to an incorrect address.

The mailing address for Program Integrity is:

Bureau of Coverage & Reimbursement Policy
Program Integrity Unit
P O Box 143103
Salt Lake City, UT 84114-3103

It is important to understand the Bureau of Medicaid Operations, Office of Recovery Services, and Program Integrity each have their own specific mailing address. Although each office may request information and process checks, each area is separate and unique. Mailing documents to an incorrect location will result in delays and inappropriate handling of your information or checks.

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06 - 81 Pharmacy Changes Effective 7/1/06

Long Acting Opiates and Methadone
An error in program interpretation reveals that prescriptions for Methadone have been allowed in the system concomitantly with long acting opiate prescriptions. Effective 7/1/06, this error will have been corrected and these duplications in therapy will no longer be allowed.

Strattera- A stand alone therapy for ADHD
Effective July 1, 2006, prescription therapies for Strattera will not be covered in combination with other ADHD stimulant therapies within the same 30 day period.

Bupropion for Smoking Cessation- ICD-9 Diagnosis Code Required
Effective July 1, 2006, prescription claims submitted for adjudication for any Bupropion product (Wellbutrin, Zyban, Buproban, Bupropion) will require one of the following ICD-9 diagnosis codes to be entered by the pharmacist: 311 (depressive disorder, not otherwise specified) for all depression related diagnosis or uses not associated with smoking cessation, and 305.1 (tobacco use disorder) for all smoking cessation uses. Only these two codes will pay; therefore, the pharmacist must categorize all prescriptions into one or the other. This will not affect the availability of any of these products since physicians will not need to write any diagnosis on the prescription.

Sedative Hypnotics- Not Indicated for Children and Adolescents
Zolpidem (Ambien®), Ethchlorvynol (Placidyl®), Glutethamide, Zaleplon (Sonata®), Ramelteon (Rozerem®), Estazolam (ProSom®), Quazepam (Doral®), Temazepam (Restoril®), Triazolam (Halcion®), Eszopiclone (Lunesta®), are not indicated and not recommended for use in children and patients younger than 18 years old. Flurazepam (Dalmane®) is not for use in children less than 15 years old. Effective July 1, 2006, Medicaid will not reimburse for these products for clients within these age groups.

Cough and Cold Preps
Beginning July 1, 2006 only the following legend cough and cold preparations will be available for coverage through the Medicaid Program:

Legend cough and cold agents used for symptomatic relief:
- Guaifenesin with DextroMethorphan (DM) 600/30 tab
- Gauifenesin with Hydrocodone 100/5 liquid
- Promethazine with Codeine

OTC List Revised
The list of over-the-counter medications available for coverage has been revised. Coverage varies from plan to plan, and as before, not all products are covered by each plan. Please consult that list for specific plan coverage. Only those products and/or formulations specified will be covered:

- Acetaminophen
- Aspirin
- Bisacodyl
- Chlorpheniramine
- Loratidine (single agent)
- Contraceptives
- Antacid Liquid and tablets
- Diphenhydramine
- Non-Oyster shell calcium tabs
- Citrate of magnesia
- Diabetic cough syrup
- Doxylamine succinate

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Docusate
Glucose blood test strips
Hydrocortisone
Loperamide
Insulin syringes with needle
Lancets
Milk of magnesia
Children's generic electrolyte solutions
Bismuth subsalicylate suspension
Prilosec OTC
Psyllium mucillid powder
Guafenesin with/without DM
Triaminic(s)
Diabetic urine tests
Ferrous gluconate and sulfonate
Clotrimazole
Ibuprofen
Insulin
Kaolin with pectin
Magnesium carbonate
Permethrin rinses
Famotidine OTC
Multiple vitamin drops for children
Pseudoephedrine 30 and 60 mg tabs
Piperonyl butoxide/Pyrethrins shampoo
Sennosides tablets
Triple antibiotic ointment

New Law for Brand vs Generic
Utah law requires the use of "A" rated generics when available. The legislature passed a new law this year that allows Medicaid to reimburse for a brand name version when investigation reveals that manufacturer rebates cause the name brand to cost less than the generic. These instances will be rare and will be subject to strict requirements on the part of manufacturers to maintain the savings in order to qualify. Notice will be provided if and when these instances occur.

Heparin Flushes
Recent Federal rulings have disqualified heparin flushes for coverage under the Medicaid pharmacy program. Any product used to "flush" or maintain an IV line is not considered a pharmaceutical and is no longer covered.

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06 - 82 Dental Program Limited

Beginning July 1, 2006, adult dental services will be eliminated for non-pregnant adults, aged 21 and older, with **Traditional Medicaid and Non-Traditional Medicaid** coverage. Also, coverage for emergency dental services will not be covered for adults after June 30, 2006.

PCN coverage for adult dental benefits will continue unchanged.

Ambulatory Surgical Center services for dental cases will continue to be covered under the existing criteria, but the dental services are not covered.

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06 - 83 Adult Vision Services Limited

Beginning July 1, 2006, adult eyeglass benefits (lenses and frames) will be eliminated for non-pregnant adults, aged 21 and older, in **Traditional Medicaid**. Exams and treatment for diseases of the eye will continue to be provided under the Medicaid medical benefit.

Non-Traditional Medicaid vision coverage remains unchanged.

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06 - 84 Speech and Language Therapy Criteria for Children

New children's criteria has been developed for Speech and Language Therapy. This was completed in conjunction with four Speech and Language therapists. All therapy continues to require prior authorization. Included below are the main items of the criteria. A complete criteria set is available in the Medicaid Speech and Language Provider Manual updated July 2006.

Covered Services for Children

1. Services for children ages 2 through 5 are covered if the child's speech or language deficit is at, or greater than one and one-half standard deviations below the mean as measured by an age appropriate standardized test for articulation, phonology, fluency or language OR if using percentile score is at or below the 7th percentile. The services will be limited to one group or individual session per week for six months or less as designated in the plan of care unless the medical need for more services is documented. One and one-half standard deviations equals 78.

2. Services for children aged 6 to 20 are available through the educational system, but additional Medicaid services may be approved if the child's speech or language deficit is at, or greater than two standard deviations below the mean as measured by an age appropriate standardized test for articulation, phonology, fluency or language or if using percentile score is at or below the 2nd percentile. The services will be limited to one group or individual session per week for six months or less as designated in the plan of care unless the medical need for more services is documented.
Two standard deviations equals 70.

3. Services for children under age 2 are not covered unless a specific medical diagnosis and the documentation supports the need and efficacy of early intervention for speech therapy. There must be a medical reason requiring such early intervention. The criteria under 1 above applies if testing is possible.

4. Services for voice anomalies such as pitch, tone, or quality, are limited to velopharyngeal inadequacies due to cleft palate, submucous cleft palate, congenital short palate, palatopharyngeal paresis/paralysis, neuromuscular diseases (myasthenia gravis, multiple sclerosis, ALS, etc.).

5. Services for voice disturbances related to vocal chord pathology or vocal chord dysfunctions are limited to 5 visits. This includes vocal chord nodules, polyps, web, mucosal edema, or granulomatosis or vocal chord dysfunctions of paralysis/paresis, hyper and hypokinesis, laryngeal dystonia, or paradoxical vocal fold dysfunction.

6. Dysphagia therapy is limited to 3 visits, consisting of a single 1-hour treatment visit per week for three weeks with the care giver present.

7. Feeding and food aversion therapy is limited to 5 visits unless the medical need for more services is supported by documentation that the child's weight is below the 10th percentile for their age appropriate weight. (See CDC charts for age appropriate weights).

8. The initial training for communication boards, such as PECS or picture boards, is limited to 3 training visits. Continued training is not covered.

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06 - 85 Medical Supplies

The following codes replace the former State "Y"-codes which were cross-walked inappropriately to L1510 and L1520:

E0637 Combination sit to stand system, any size, with seat lift feature, with or without wheels, limited to ages 2-20, no prior authorization required.
E8000 Gait trainer, pediatric size, posterior support, includes all accessories and components, limited to ages 2-20, requires prior authorization.
E8001 Gait trainer, pediatric size, upright support, includes all accessories and components, limited to ages 2-20, requires prior authorization.
E8002 Gait trainer, pediatric size, anterior support, includes all accessories and components, limited to ages 2-20, requires prior authorization.

Opened Codes

L3807 Wrist-hand-finger orthosis, w/o joint, prefab, fitting, no prior required
L3911 Wrist-hand-finger orthosis, elastic, prefab, fitting, no prior required
E1028 Wheelchair Accessory, Manual swingaway, retractable or removable mounting hardware or joystick, other control interface or positioning accessory. Prior authorization required.
K0043 Foot rest, lower extension tube. Prior authorization required.

Corrections

A6550 Dressing set for negative pressure pump. The unit limits were incorrect in the previous manual; the limit is 15 per month or 1 every 2 days.
A7000 Canister or pump, replaced A6551, now requires a prior authorization. It is limited to 10 units per month or 1 every 3 days.

Supplemental Nutrition

In the past Medicaid has not covered supplemental nutrition, but only "total nutrition" if administered through a tube. Supplemental nutrition is supplementing a traditional age-appropriate diet with enteral nutrition products. The criteria has been modified to allow some limited supplemental nutrition.

(1) Supplemental nutrition and appropriate supplies are covered for children (through age 20) with partially functioning gastrointestinal tracts. The supplemental nutrition must be administered through a tube, or it may be consumed part orally and part administered through a tube. The following conditions apply:

- the child has a disease of the small bowel or stomach that impairs digestion and/or absorption of an oral diet. (Examples might be conditions resulting from: pancreatic insufficiency, pancreatitis, cystic fibrosis, Crohn's disease, celiac disease, ulcerative colitis with malabsorption, short bowel syndrome, parenchymal liver disease, cholestactic liver disease.)

Or, if two of the following conditions are documented:

- the (0-2y) child with growth potential is at or below the 10th percentile on the CDC Growth Charts: US, Weight for Age Percentiles chart for age and gender for the past 3 months or more, OR the (2-20 year old) child with growth potential is at or below the 5th percentile on the CDC Growth Charts: US, BMI Index for Age Percentiles chart for age.
- the child has reached a plateau in growth for more than six months.
- the child has already demonstrated a significant decline in weight within the past three months prior to the nutritional assessment.
- the child is not able to consume or eat more than 25% of their nutritional requirements from age-appropriate food sources.

(2) For children and adults, oral supplemental nutrition is covered to treat Inborn Errors of Metabolism. In patients with inborn metabolic errors, the metabolic pathway is disrupted and excessive accumulation of an amino acid or other product results. These conditions are treatable by the dietary restriction of one or more amino acids. (Examples are: Maple syrup urine disease [MSUD] type Ib and II; phenylketonuria [PKU]; homocystinuria; tyrosinemia types, I, II and II; glutaric aciduria/glutaric acidemia type I and II; methylamalonic acidemia; histideinemia; cystinuria types I and III, Hartup disease.)

(3) Medicaid may approve nutritional supplements for covered infants and children ages 0 to 5 who live at home and are in the WIC program, for quantities which exceed the WIC program allowed amounts. If a tube is required, supplies and pumps may be authorized. One of the following conditions must be documented:

(a) The target weight of the child cannot be attained with expected oral feedings;
(b) The oral feedings are present but too extended due to weakness, illness, or disease to the infant; or
(c) The child is concurrently using a ventilator or oxygen, or has a tracheostomy and is unable to reach or maintain age appropriate weight.

All other supplemental nutrition is not covered by Medicaid. Most enteral products are available from a local grocery store with a pharmacy by using food stamps. The client should request the in-house pharmacy to order the enteral products which can then be carried through the grocery line and paid for with food stamps.

Intermittent Urinary Catheter Criteria:

Intermittent urinary catheterization is covered if medically necessary and the recipient or caregiver can perform the procedure. When clean, non-sterile catheterization technique is used; Medicaid will provide 10 intermittent catheters per month unless there is documentation of the medical necessity for sterile technique.

When sterile catheterization is necessary, up to 100 catheters per month may be approved through prior authorization. It is expected that most sterile catheterizations will be temporary measures for short periods of time. The recipient using sterile technique must meet one of the following criteria:

1. The recipient is immunosuppressed, for example (not all-inclusive):
   - on a regimen of immunosuppressive drugs post-transplant,
   - on cancer chemotherapy,
   - has AIDS, or
   - has a drug-induced state such a chronic oral corticosteroid use.
2. The recipient has radiologically documented vesico-uretheral reflux while on a program of intermittent catheterization.
3. The recipient is a spinal cord injured female with neurogenic bladder who is pregnant (for duration of pregnancy only).
4. The recipient has had distinct, recurrent urinary tract infections, while on a program of clean, non-sterile intermittent catheterization, twice within the 12-months prior to the request for sterile intermittent catheterization.

Use of Coude (curved) tip catheter in females is rarely medically necessary. A Coude tip catheter is considered medically necessary for either male or female recipients only when a straight tip catheter cannot be used.

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06 - 86 CHEC Manual (Appendix B) Updated for Pediatric Dental Varnish

A section is added defining a new optional service for the application of dental varnish to SECTION 2.

1. 3-2 The CHEC Program has included definitions and information concerning the effective application of dental varnish during a well child exam in children age 0-4:

- Recommendations
- Definitions
- Provider requirements

Fluoride varnish has been shown to reduce the incidence of dental caries by approximately 40% compared to other preventative treatments. It is a lacquer-based product containing fluoride (NaF varnish with 2.26% fluoride) applied topically to the teeth. It forms a deposit on the dental enamel that will slowly release a high concentration of fluoride ions into the dental enamel. It is effective in preventing tooth decay and remineralizes tooth damage caused by the decaying process.

The revised SECTION 2 is on the Internet. Look for the link to the CHEC Manual at: http:health.utah.gov/medicaid/pdfs/CHEC . If you do not have Internet access, contact Medicaid Information for a copy of the revised CHEC Manual or use the Publication Request Form.

If you have questions, contact Russ Labrum, CHEC Program Manager, at (801) 538-6206 or rlabrum@utah.gov. □

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06 - 87 CHEC Manual Updated for Maternal Depression

The Utah Medicaid Provider Manual for Child Health Evaluation and Care Program (CHEC) Services has been updated.

A section is added defining new suggested screening for Maternal Depression at Well Child Visits (WCV) to SECTION 2, 3-4 Mental Health. It reads as follows:

Depression is one of the most common yet most unrecognized, undiagnosed, and untreated complications of pregnancy. Maternal depression refers to a range of depressive conditions that can occur either during pregnancy or in the first 12 months after delivery. In addition to being debilitating to women, infants and young children of depressed mothers may experience a range of problems including lower activity levels, fussiness, problems with social interactions, and difficulty achieving age-appropriate developmental and cognitive milestones.

Pediatric providers (e.g., pediatricians, family physicians, nurse practitioners) play a key role in early intervention for maternal depression. Nearly all new mothers come in contact with pediatric providers numerous times during the first year of their child's life through well-child visits (WCV) and other pediatric visits. Use a validated screening tool to identify new mothers for depression needs, or further assessment or treatment.

These are the recommended depression screening tools:

2-question Patient Health Questionnaire (PHQ-2) http://www.depression-primarycare.org/ or http://www.pfizer.com/pfizer/download/do/phq-9.pdf
9-question Patient Health Questionnaire (PHQ-9) (see above)
Edinburgh http://www.dbpeds.org/articles/detail.cfm?TextID=485
Beck Depression Inventory-II (BDI-II) Psychological Corporation
Family Psychosocial screen (FPS)
http://pedstest.com/content.php?content=download_resources.html

This is when we recommend you use these tools:

1. As mothers bring their young children to their health care provider for scheduled Well Child Visits.
2. In hospital 3-7 days following birth, at 2 weeks, and at 2 months.

The revised SECTION 2, Mental Health 3 - 4 is on the Internet. Look for the link to the CHEC Manual at: http:health.utah.gov/medicaid/pdfs/CHEC. If you do not have Internet access, contact Medicaid Information for a copy of the revised CHEC Manual or use the Publication Request Form.

If you have questions, contact Katie Smart, Children's Mental Health Specialist, at (801) 538-9192 or ksmart@utah.gov.

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